PPO Serve
Better Care. Lower Cost. Inspired Clinicians.

Dear Colleagues

PPO Serve suggestions to HMI following the publication of The Provisional Findings and Recommendations report

Firstly, permit us to commend the HMI team on a fabulous piece of work that is this report. Your country owes you much gratitude for this important contribution to the reform of our system of healthcare delivery. Both the detailing of the diagnostic critique of the sub-optimal performance of private healthcare and the issues that lead to this situation; and your recommendations as how to address and fix the problems are accurate and welcome.

We would like to make a few comments about your findings, share some of our own experiences of innovation suppression by monopoly power, and then suggest some refinements and make additional suggestions about the recommendations.

1. **On the funders:**
    a) Your report might have usefully also measured the enormous variation in, and over usage of **adult medical admissions and bed days** in many areas. This is because of the plentiful beds but also because of the **profound weakness of out of hospital PHC services** based on the individual GP service model created by the FFS system; the oversupply of competing hospital-based specialists, and the increasingly scant out of hospital benefits. This is a major source of avoidable system costs.
    b) We believe that **FFS** remuneration schedules that do not support teamwork should be **abolished as soon possible**.
    c) We share a summary of the problem that might be useful: the Medical Schemes Act is based on a 'purchaser vs. provider separation' to manage the system – it fails when the **purchasers don't purchase**. As you note, the large commercial schemes serve their members poorly, and you appropriately detail the reasons.
        - PPO Serve directly experiences this **resistance to purchase value** by the funders for the members by alternative fee contracts that support teamwork to produce high volume and quality care at low cost. We propose that mature versions of such models can reduce system costs by 50% and more, especially as they massively reduce the need for hospitalisation.
        - Despite ours being a **unique local accountable population medicine integrated multi-disciplinary care team** that is based on this reforming framework, and showing considerable promise, Discovery Health, Medscheme and MMI have all informed us, and the industry, that they themselves will deliver the needed supply side reforms, by owning their own suppliers, or by claiming false equivalence with their managed care role and their DSPs. **They have not supported our model**. Their agents, whose role is to purchase valuable care from innovative supply side models, instead see us as competition and disengage (or just don't engage) or frustrate the process at every turn.

- In doing this that they act against the best interests of their members and **perversely violate their 'agency' role**. They have experienced no questions or reprimands from the CoMS. Only the non-commercial scheme GEMS, and more recently Polmed, have pursued the development of the alternative reimbursement contracts that support the teams that deliver integrated care.

d) We recommend that similar **size constraints** to those you have recommended for hospitals be also placed on the commercial Schemes – namely a 20% national cap, and we would further propose a 30% regional cap (subject to local factors). It is crucial that no one funder can block local reform initiatives.

2. On the supply side:
   a) We are **delighted** with your proposal regarding the creation of an overarching **Supply Side Regulator,** with its specified functions, having argued for this for many years.
   b) We recommend that in addition to the national cap, you also propose a **regional cap of 30%,** subject to local factors such as small population size.

Kind regards
Brian Ruff

CEO PPO Serve